



2009 Medicaid Transformation Program Review Third Party Liability (TPL)

Description

Third Party Liability (TPL) is a federally required program that helps to ensure Medicaid and the State are the payors of last resort. Liable third parties may include:

- private insurance carriers,
- work-related health insurance,
- medical support from absent parents,
- Medicare,
- providers,
- automobile insurance,
- court judgments or settlements from a liability insurer,
- worker's compensations,
- first party probate estate recoveries,
- and occasionally a beneficiary who has received payments from their health plan, that should have been paid directly to the Medicaid Agency.

This program review will only deal with private insurance carriers, work related health insurance and Medicare.

Once liable third parties have been identified, one of two techniques are implemented; 1) cost avoidance and 2) post pay recovery (pay and chase). Cost avoidance is a federal requirement. If a Medicaid beneficiary has private health insurance, services rendered to that beneficiary must be charged to the private health insurance prior to being charged to Medicaid. Approximately 10% of Medicaid beneficiaries have private health insurance. Cost avoidance is the most cost effective method for the State to achieve cost savings and the results are immediate.

KHPA also generates cost savings through the operation of programs such as Health Insurance Premium Payment System (HIPPS) and Medicare Buy-In. Under KHPA oversight, HP Enterprise Services operates and maintains the HIPPS and Medicare Buy-In program. HIPPS is a process through which KHPA can use Medicaid monies to purchase private health insurance for a Medicaid beneficiary through a private insurance company if it is cost effective. The private insurance company is then responsible for the beneficiary's medical expenses, and Medicaid becomes the secondary payer. HIPPS participants are referred to the HP Enterprise Services TPL unit and an initial cost effectiveness determination is made at that time. Referrals can be made by any provider, any beneficiary or any Medicaid eligibility worker. Most referrals come from eligibility workers. Cost effectiveness is evaluated every six months thereafter.

Most of the day-to-day TPL duties are contracted out to HP Enterprise Services, the fiscal agent of KHPA. HP Enterprise Services uses the Medicaid Management Information System (MMIS) to maintain the TPL database and ensure that medical costs that should be paid by other parties are avoided when appropriate. HP Enterprise Services receives TPL leads from a variety of sources including Medicaid providers, other State agencies, and the Medicaid beneficiaries themselves. All the leads are verified by HP Enterprise Services for accuracy prior to being entered into the MMIS system. On average, through the first half of SFY 2009, HP Enterprise Services worked through an average of 8,609 TPL leads a month.

If TPL is discovered subsequent to Medicaid payment, then the TPL program will seek reimbursement from the Third Party Resource (TPR) using the post pay recovery process. In order to receive Medicaid a beneficiary must assign their rights to payment from any TPR. This allows KHPA to receive reimbursement prior to any payment to the beneficiary even in a Medical Subrogation case. If approved by the TPL manager, costs associated with certain specialized cases can be changed to pay and chase. HP Enterprise Services contracts with Health Management Systems (HMS) to provide cost recovery services. HMS maintains a national TPR system which it uses to conduct data matches against the KHPA beneficiary files and locate potential TPL leads. Each lead is then verified, prior to HMS making any attempts to collect from the TPR.

When money is recovered from a dual eligible beneficiary (a beneficiary who is both Medicare and Medicaid eligible) after Medicaid has made a payment, a process called Medicare Disallowance is utilized. Medicare will not pay Medicaid directly as a reimbursement for Medicaid's previous payment. Therefore, when dual eligibility is discovered after Medicaid has made a payment to the provider, Medicaid sends a letter directly to the provider of the services. The letter states that the beneficiary to whom the services were provided had Medicare eligibility and that the provider should bill the claim to Medicare. Once Medicare pays the provider for the services, then Medicaid will recover its original payment from the provider. If any additional payment is due for the services, the remaining bill request is sent to Medicaid. In this manner Medicaid is returned to its rightful position as payor of last resort.

Activities and Expenditures

Figure 1 displays the amount of money that is avoided as a cost to the Kansas Medicaid Program through TPL each year for the past four fiscal years. KHPA has not been able to identify a conclusive reason for the decrease in cost avoidance between SFY 06 and 07 for Medicare. It was speculated that the drop in cost avoidance is tied to several different events occurring between January 2006 and fall of 2007; however a specific amount can't be attributed to each specific event. Some of the events include an increase in Medicare Part C (Medicare Advantage plans), decreases in Medicare payments, and increases in Medicaid reimbursement rates.

Figure 1: Cost Avoidance

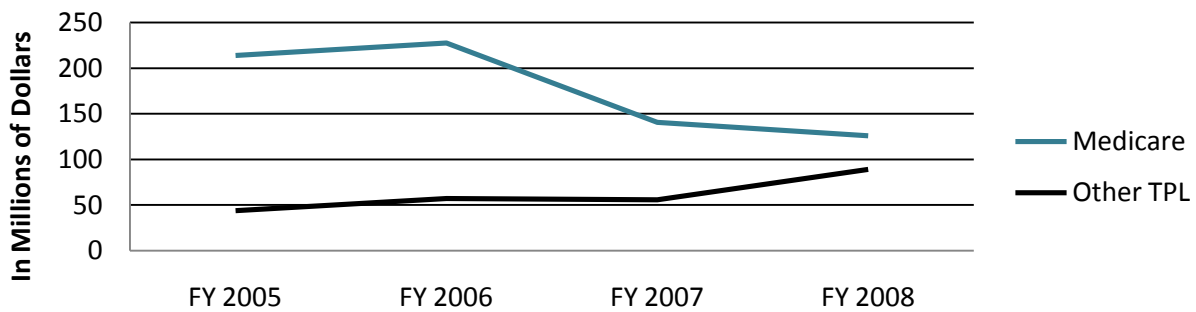
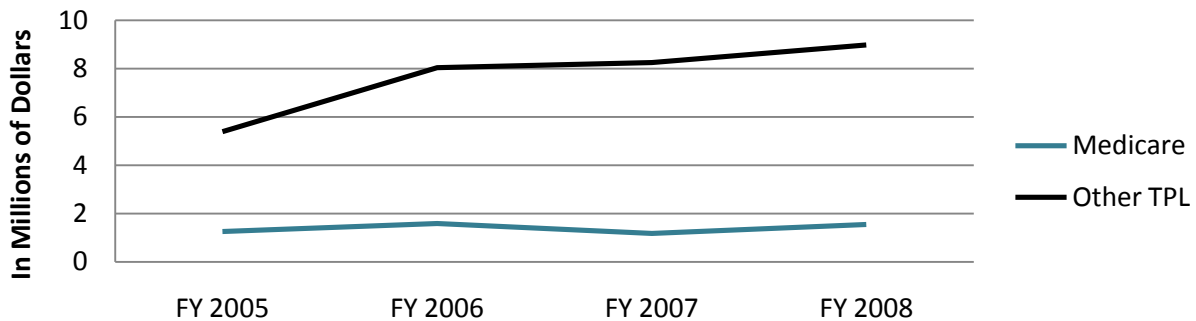


Figure 2 displays the amount of money recovered after the initial Medicaid payment each year over the last four state fiscal years.

Figure 2: Post Pay Recovery



Figures 3 and 4 both show a comparison between the State of Kansas and eleven other states that currently contract with HMS. Both figures are based on numbers for calendar year 2008. Figure 3 shows the amount that Medicaid paid and then attempted to recover from private health insurance companies through HMS. Figure 4 shows the percentage of recovery the HMS showed on the amount billed to private health insurance companies. Kansas is the first state listed in both figures.

Figure 3 – Amount Billed to Other Insurance by Medicaid

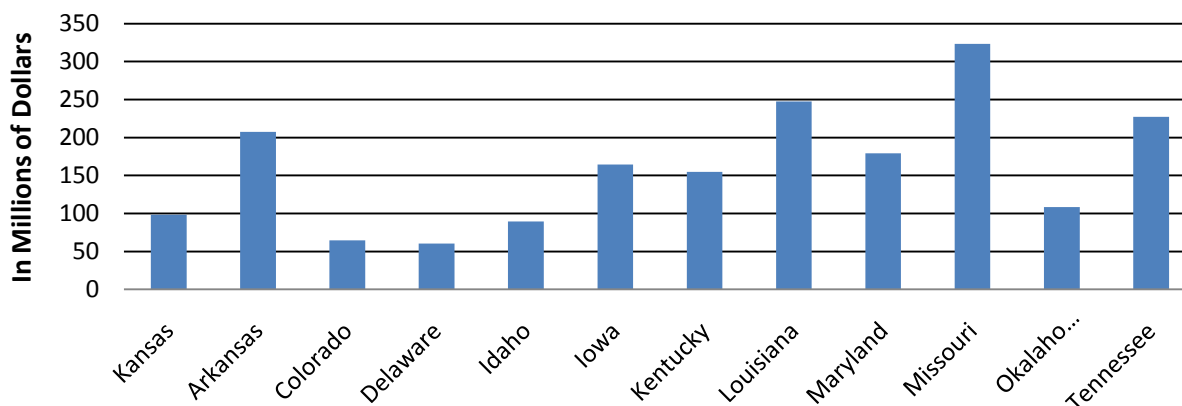
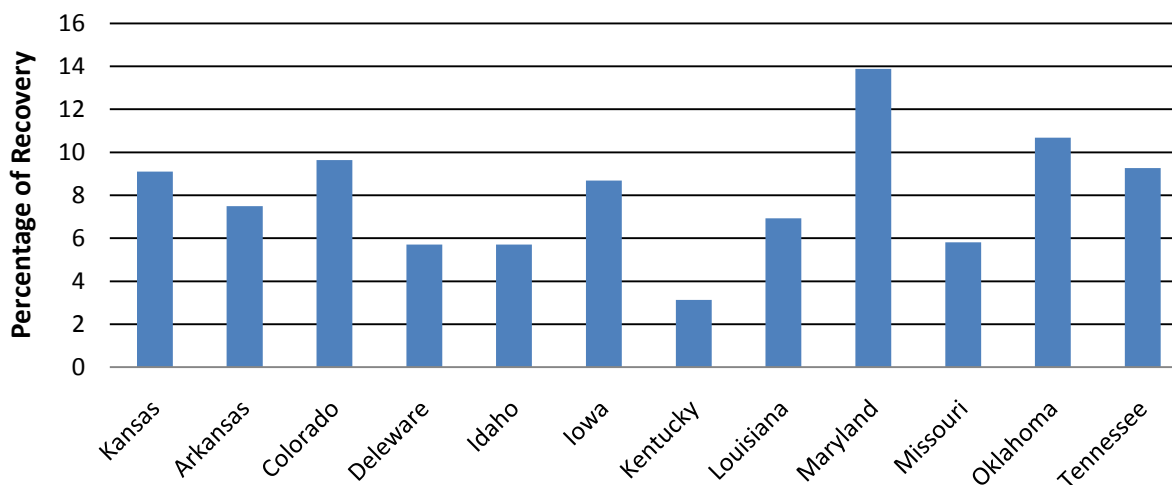


Figure 4 – Comparison of Recovery Rates for States Using HMS for Cost Recovery



The total estimated cost of operating the TPL program was \$1.25 million in SFY 2008 and \$1.21 million in SFY 2007 (This includes State costs and contract costs). Although there are occasional increases in costs as a result of implementation of new policies, the costs of the TPL program have remained relatively stable. There is no increase in cost to the TPL program directly related to increasing cost avoidance. Cost avoidance, as a cost savings technique, guarantees a definite amount of costs to the State will be avoided. Cost recovery, on the other hand, can be unstable and there is no guarantee that the money paid out by Medicaid will be recovered. During the 13 month span between December 2007 through December 2008, HMS billed a total of \$116.28 million to private health insurance companies and collected \$10.17 million, or roughly 9% of the amount HMS billed. This information is based upon a recently created report that was not run prior to January 2008. The amount of time given to the private health insurance companies to pay the billed amount was not factored into this percentage. It should be noted that HMS can and will bill a TPR for reimbursement for up to three years after discovering the TPL and seek the reimbursement for up to six years if the TPR was originally

billed within the first three years. So some cost recovery can occur at a much later date than the original date of payment.

Figure 5 shows the comparison between cost avoidance and cost recovery in total money saved. The vast discrepancy between returns on cost avoidance expenditures and cost savings expenditures is why it is important for the TPL program to emphasize cost avoidance as its prime goal. The more money that can be saved up front, the less money the TPL program will need to be concerned with collecting later. While some new cost avoidance techniques can be costly and time consuming to implement, the money the state saves as a result can be seen immediately. On the other hand it can take years to show complete results through implementation of a new cost recovery technique. The key to effective cost avoidance and cost recovery is to have and maintain a comprehensive and accurate list of TPR within the MMIS system.

Figure 5 – TPL Technique Comparison FY 2008

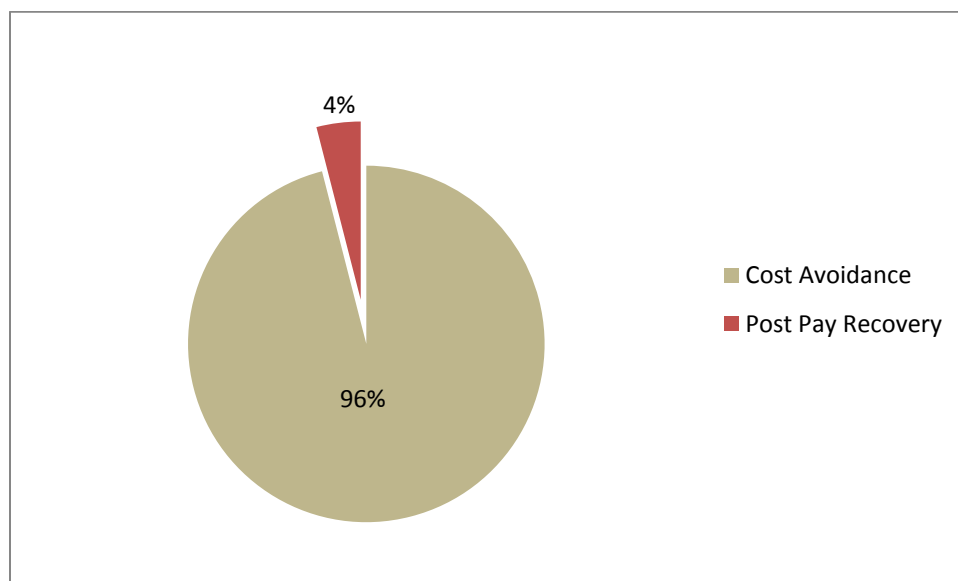


Figure 6 shows the number of Medicaid beneficiaries enrolled in the HIPPS program over the last four fiscal years. A consumer is an eligible beneficiary who uses a program within the selected time period. The drop in HIPPS enrollment between SFY 2006 and SFY 2008 is the result of a few factors coming into play. First, the number of referrals for the HIPPS program has significantly decreased since SFY 2005. Second, the cost effectiveness determination every six months results in several HIPPS participants being disqualified for the program. Third, HIPPS participants can and do lose their Medicaid eligibility and therefore must be dropped from HIPPS participation. Without increasing the referrals into the HIPPS program more participants were lost than gained during that time period. This trend reversed itself recently as fewer beneficiaries were disqualified for losing Medicaid eligibility and/or cost effectiveness. There was also an increase in HIPPS referrals received which resulted in the increase in average HIPPS enrollment at this point in SFY 2009.

Figure 6 – Average HIPPS Consumers

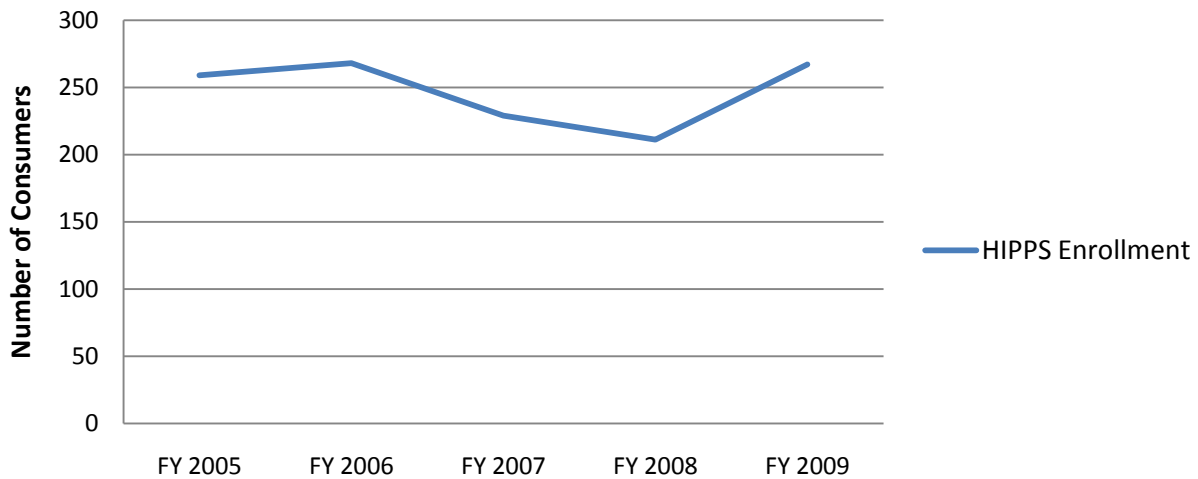


Figure 7 shows the increase in average enrollment in the Medicare Buy-In program over the course of the last four years. Average participation in the Medicare Buy-In population is steadily increasing as the number of persons reaching the age of 65 and becoming eligible for Medicare also increases.

Figure 7 – Average Buy-In Consumers

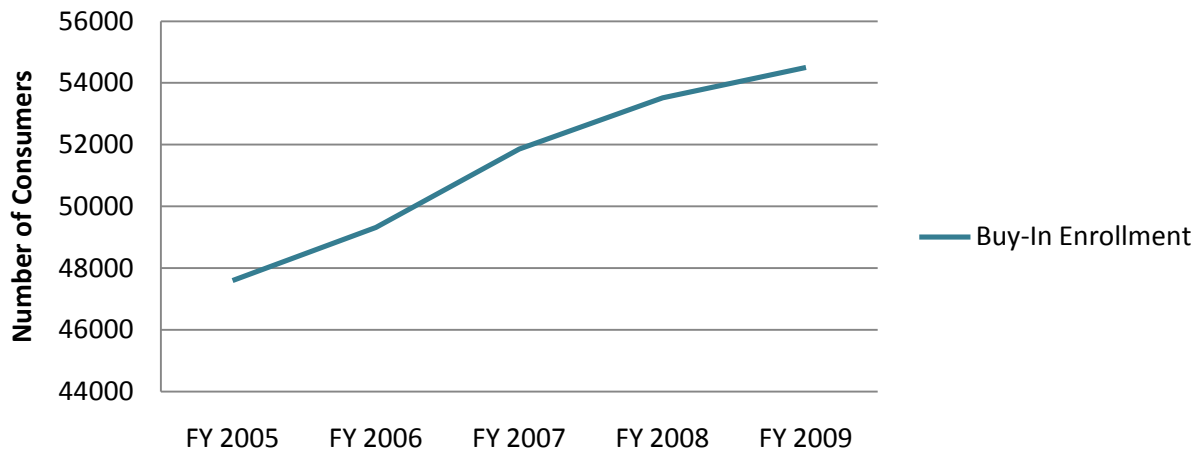
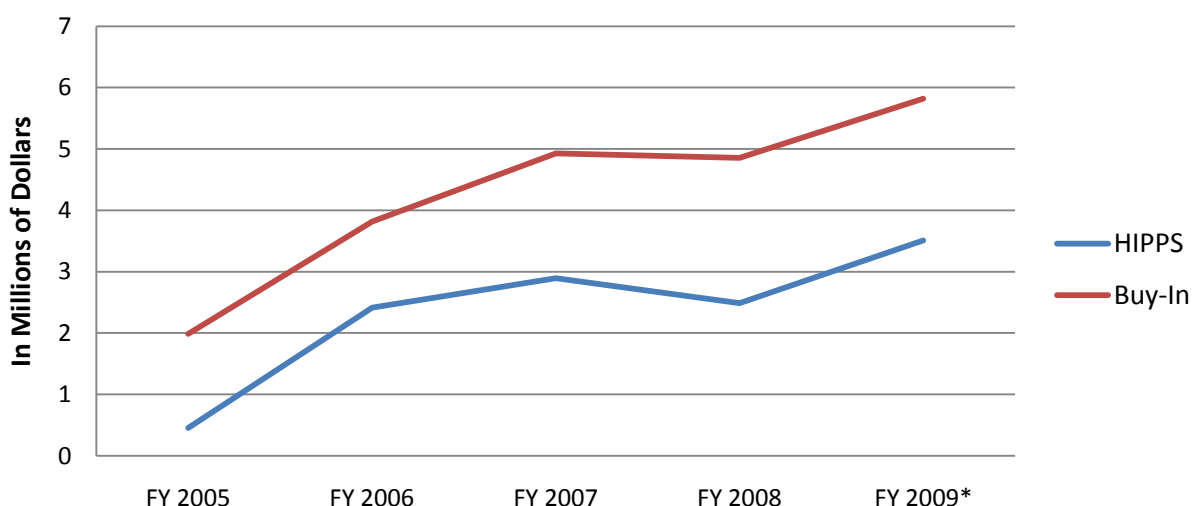


Figure 8 compares the cost avoidance numbers of the HIPPS program and the Medicare Buy-In program over the last four fiscal years. The numbers are in millions of dollars. The asterisk next to SFY 2009 signifies the fact that these are projected cost avoidance numbers based upon the first eight months of SFY 2009.

Figure 8 – Cost Avoidance from the HIPPS and Buy-In Programs



Proper utilization of the TPL programs can result in substantial monetary benefits for the State Medicaid agency as displayed in Figure 1.

Changes were recently made to Pharmacy claims converting them from pay and chase to cost avoidance via policy E2008-057. This new policy will hopefully result in a cost savings of roughly \$9-10 million dollars a year. Using pay and chase, roughly \$108,000 of the approximately \$900,000 of Medicaid pharmacy payments each month were recovered. The new policy went into effect on January 12, 2009 and in each month thereafter there was a cost avoidance of approximately \$1,000,000 each month.

Changes are being made to avoid Medicaid making payments to providers for the primary insurance company's contractual write-off amount. The contractual write-off amount is the amount of money that the provider has agreed to write-off from his customary charge as part of his participation agreement with an insurance company. It should not be paid for by Medicaid. The expected savings from the implementation of this policy change are relatively small. This is because the Medicaid allowed amount is generally less than the insurance company's allowed amount and therefore Medicaid generally does not pay anything on these claims. It should also be noted that as only roughly 10% of Medicaid beneficiaries have private health insurance this situation does not arise very often.

Program Evaluation

There are opportunities for potential savings through making better use of the HIPPS program. The best opportunity to increase potential savings through the HIPPS program is through better education of the beneficiaries and the Medicaid eligibility workers. If the beneficiaries and eligibility workers have a better understanding and knowledge of the HIPPS program it will likely lead to increased participation in the program and a greater cost savings to the State. The HIPPS cost effectiveness equation and actuarial data should also be reviewed to ensure that it is up to date.

The process for EDS and HMS to update and share TPL and TPR information should be further evaluated to determine if there is a more efficient means of cost recovery and of obtaining and

verifying TPL leads from HMS. Currently KHPA is exploring the idea of expanding Medicare Disallowance to include private health insurers. Instead of HMS billing the private health insurance company, HMS will provide sufficient information to the provider of the services and the provider will bill the private health insurance company. If the health insurance company issues payment to the provider for the services, HMS will set up a recovery of Medicaid's initial payment to the provider. If the private health insurance does not pay, the Medicaid payment is not recovered from the provider. This idea will likely be accepted by providers as they should receive a higher payment for the services from the private health insurance company.

The TPL policies are in the process of being consolidated so that they are easier to locate and identify. Currently TPL policies are not separated from other policies; they are only separated by year and order initiated. Policies describe how the TPL program is administered and instruct providers how to bill their claims when TPL exists. Consolidation of the policies will make the policies more accessible and identifiable by providers who need that information when billing for services. Consolidation results in administrative simplification for both the agency and the providers.

A properly administered TPL program can ensure great cost savings to the state. . [Although the TPL Program in Kansas is efficient, it is not as efficient as it could be. For example, cost avoidance is generally more effective in ensuring payment accuracy. Medicaid payment policies and billing patterns change constantly, requiring a continuous effort to develop or purchase cost avoidance techniques in order to avoid unnecessary or inappropriate billing. The TPL program should continue to increase its TPR database to maximize cost avoidance. Cost recovery should remain a viable fallback option, and there should be further research into opportunities to increase cost recoveries.

Recommendations

1. Consolidate the TPL policies for improved efficiency of the TPL program by allowing easier and quicker access to all the TPL policies;
2. Increase the number of beneficiaries enrolled in HIPPS to increase cost savings to the State by better educating the beneficiaries on the benefits of the program and the Medicaid eligibility workers on spotting the potential for a beneficiary to gain health care coverage through his/her employer. Review and evaluate the HIPPS cost effectiveness equation and actuarial data;
3. Increase cost recovery through HMS through expansion of the Medicare disallowance project to include private health insurers. This would increase cost savings to the State and overall provider well-being as the provider should receive more money from the private insurance company than from Medicaid;
4. Increase TPR database in order to maximize cost avoidance potential and increase cost savings to the State through a thorough evaluation of the HMS data-match process and how EDS updates the MMIS system. The evaluation should help identify any gaps in the process and increase overall efficiency.
5. Improve communications between TPL and Child Support Enforcement (CSE) to ensure that information about absent parents, who are responsible for health insurance

coverage of their children, is accurate. This will improve our ability to increase up front cost savings by ensuring the proper party is billed for the services first.

APPENDIX A: DEFINITIONS

Child Support Enforcement (CSE) – The State Title IV-D agency. Works to enforce child support and medical support orders and obtains TPL information from absent parents which is then used as a potential TPL lead.

Dual Eligible Beneficiary – A person who is eligible for both Medicare and Medicaid concurrently.

Health Insurance Premium Payment System (HIPPS) –A program through which KHPA spends Medicaid monies to purchase health insurance for Medicaid beneficiaries when it is determined to be cost effective to do so. The cost effectiveness determination involves a comparison of estimated costs Medicaid would spend on the beneficiary compared with the cost of paying monthly premiums to the private insurance company for the same beneficiary.

Medical Subrogation – A federally mandated collections program aimed at recovering costs from 3rd party tortfeasors (explained separately), their insurers and other parties deemed liable for medical care to Medicaid recipients. As part of the application for Medicaid, recipients assigned their rights in these matters to the state.

Medicare Disallowance – A process of cost recovery involving Dual Eligible's. As Medicare will not reimburse Medicaid for payments, the provider of the services is required to submit a bill to Medicare requesting payment for services. Upon Medicare's payment to the provider, Medicaid will recover the money that it initially paid the provider and return to its rightful role as payor of last resort.

Third Party Liability (TPL) – The liability, of a person or entity, to the Medicaid agency or to a provider for medical costs; also the name of the program which operates and maintains the cost savings program for the state Medicaid agency.

Third Party Resource (TPR) – A person or entity which may have liability for payment or reimbursement. Liable third parties include: private insurance carriers, work-related health insurance, medical support from absent parents, Medicare, providers, automobile insurance, court judgments or settlements from a liability insurer, worker's compensations, first party probate estate recoveries, and occasionally a beneficiary who has received payments from their health plan, that should have been paid directly to the Medicaid Agency.

Tortfeasor – A person who commits a tort (civil wrong), either intentionally or negligently.